APPEAL NO. 93063

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 through 11.10 (Vernon Supp. 1993) (1989 Act). A contested case hearing was held in (city) on December 14, 1992. The issues before hearing officer (hearing officer) were as follows: whether the claimant injured his neck as well as his back in a work-related accident on (date of injury); whether claimant has reached maximum medical improvement (MMI) from his work-related injuries of (date of injury); and what is claimant's correct impairment rating based on his injuries of (date of injury). The appellant (claimant herein) appeals the hearing officer's determination that he injured his back but not his neck in a work-related lifting incident on June 24th; he also appeals the determination that he had a 14% impairment from his compensable back injury, as found by the designated doctor appointed by the Texas Workers' Compensation Commission.

DECISION

We affirm the decision and order of the hearing officer.

The claimant was employed by Capform, Inc. (employer) on (date of injury). He was injured on that date when, assisted by others, he lifted a 400-pound form whose weight was supported by his head. Claimant, whose testimony was translated into English by a translator, stated that he experienced pain from his neck to his hips, with most of the pain concentrated in his lower back.

The claimant was seen in the emergency room, HCA Medical Center of Plano, the same day. The discharge instructions, which prescribe bed rest and medication, show a check in the box next to the preprinted category "back and neck injury." Beginning July 2nd, claimant began treating with (Dr. H); on that date Dr. H examined the claimant and found tenderness in the mid and lower thoracic and lumbar areas, but a normal cervical spine. On July 16th, August 1st, and August 26th, Dr. H reported claimant was still experiencing lower thoracic and lumbar pain which was radiating down his legs. A September 9th CT scan of the lumbar spine from L3 to S1 disclosed spondylolysis at L5-S1, moderate diffuse disk bulge at L4-5, and mild central disk bulge at L5-S1. An October 10th thoracic CT scan was normal.

The claimant was examined by (Dr. W), a Commission-appointed designated doctor. Dr. W's October 14th report noted claimant's complaints of cervical and thoracolumbar pain, and stated with regard to claimant's current status, "[s]till having cervical pain, lumbosacral pain with some right leg pain." However, based upon review of claimant's medical records Dr. W said he was "unable to really discern whether the cervical and thoracic parts were part of the original injury. Most of the records center on the lumbosacral spine." Dr. W's physical examination of the cervical spine disclosed some mild tenderness, splinting and guarding. Range of motion was found to be normal. However,

Dr. W found MMI as of October 14th and assigned an impairment rating of 18%[1] if the cervical spine is included, 14% if only the lumbar spine is included. This was due to Dr. W's inability to determine from the patient and the records whether the cervical spine should be part of the impairment rating.

Because the claimant experienced only minimal improvement with physical therapy, Dr. H referred him to (Dr. HI) for further evaluation. Dr. HI ordered tests including total myelogram and post-myelogram CT scan cervical and thoracic spine and lumbar spine. The February 13th report included the impression of normal cervical and thoracic myelogram and post-myelogram CT scan, C4 to T1 and T1 to T5. Dr. HI also ordered a dermatomal somatosensory evoked potentials (DSEP), upper extremities, the October 31st results of which were found to be "compatible with a focal demylinating (sic) lesion vs. conduction defect in the large fiber sensory system, vs. nerve root lesion at C7 and C8 on the left, vs. cervical radiculopathies, all as a result of spinal cord trauma." The report stated further evaluation and clinical correlation were warranted.

On November 19th Dr. HI stated he would concur with Dr. W's MMI and 17% impairment rating, except for the fact that Dr. W did not take into account claimant's nerve damage as demonstrated by the DSEP. He added, "I believe this adds an additional 12% permanent partial impairment using combined tables that would be a 27% impairment as (sic) the man as a whole, rather than the 17%. . . ."

The claimant was also examined by carrier's doctor, (Dr. S), who stated on November 21, 1991 that the claimant reported his neck pain had been present since the time of the accident, although he described it as intermittent and worse when his lower back hurts. Dr. S did not certify MMI as the result of that exam, although he did note claimant's range of motion of the neck to be full. Pursuant to a re-exam of June 22, 1992, Dr. S noted the claimant described almost constant back pain, and that sometimes he had neck pain. Again, Dr. S found full ROM in the neck, and he certified MMI as of June 21st, with a 14% whole body impairment.

The claimant testified that his neck began to hurt more following his myelogram. His August 24, 1991 notice of injury stated, "I lifted a form causing injury to my back, right arm, right shoulder and body in general." Claimant's answers to carrier's interrogatories indicated that parts of the body affected by the injury were "Back, right arm and right shoulder." Testimony was elicited at the hearing concerning possible confusion over the terms "back" and "neck" due to claimant's limited use of English. The claimant testified

[1] Dr. W's narrative report assigns 18% impairment if cervical spine is included, although his TWCC-69 states 17%.

that, to him, "back" referred to the entire spine, including his neck. However, at the hearing he also described "neck" and "back" separately; he stated variously that he had no trouble communicating with his doctors, but that perhaps they had not understood him when he described his problems.

In his appeal, the claimant challenged the hearing officer's findings of fact and conclusions of law which held that the claimant did not injure his neck on (date of injury), and that his impairment rating was 14%. Claimant contends that the preponderance of the evidence--including claimant's own testimony, the ER report, neurological report, and records of Dr. S--indicate that he suffered a neck injury at the same time he injured his back. He also notes that the designated doctor's report indicates the presence of a neck injury and assigns a 17% impairment rating for both injuries. In its reply, the carrier contends the hearing officer's determination that claimant suffered no compensable neck injury is supported by the evidence of record, including claimant's failure to mention a neck injury to numerous doctors and in reporting his injury. With regard to the impairment rating, the carrier states that the 14% is supported by the opinions of Drs. W and S, and that Dr. W clearly was unable to establish that claimant's neck problems were part of this claim.

We hold that the hearing officer's determinations regarding claimant's neck injury and impairment rating are supported by sufficient evidence. There was some conflict in the testimony and in the evidence regarding what the claimant described to his doctors; however, the hearing officer as fact finder was entitled to resolve such conflicts against the claimant. The hearing officer is the sole judge of the relevance and materiality of the evidence offered and of its weight and credibility. Article 8308-6.34(e). He may believe all, part, or none of the testimony of any witness; judge credibility; assign weight; and resolve conflicts and inconsistencies. Ashcraft v. United Supermarkets, Inc., 758 S.W.2d 375 (Tex. Civ. App.-Amarillo 1988, writ denied). Despite some evidence to the contrary, there was sufficient evidence from which he could conclude that the claimant did not complain of neck problems until several months following the accident, and that claimant understood and was able to articulate a distinction between "back" and "neck." We thus affirm the hearing officer's determination that the claimant failed to meet his burden of proof to establish that his neck problems arose out of and in the course and scope of his (date of injury), injury.

The 1989 Act provides that a designated doctor's report determining impairment shall have presumptive weight, and the Commission shall base its determination on that report unless the great weight of the other medical evidence is to the contrary. Article 8308-4.26(g). In this case, the designated doctor apparently rendered alternative impairment ratings, although the higher of the two was qualified by the doctor's inability to determine whether the cervical spine should be rated. Under these circumstances, the hearing officer properly considered all the medical evidence in the record before determining that Dr. W's 14% impairment rating was not contrary to the great weight of the other medical evidence--the other medical evidence presumably including Dr. W's own, but conditional, higher

impairment rating. We cannot say that this conclusion was error or was not supported by sufficient evidence. We therefore affirm the hearing officer's determination that the claimant's impairment rating was 14%.

The decision and order of the hearing officer are affirmed.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Joe Sebesta
Appeals Judge